Provider Contract Policies and Procedures for Managed Care Plans

Agreements between a managed care plan and a provider must include the following provisions.

1. "**Hold Harmless**" clause for managed care plans, provides that a member is not responsible for payments to a provider under any circumstance, including:
    - Nonpayment of moneys due the providers by the managed care plan,
    - Insolvency of the managed care plan or,
    - Breach of the agreement, other than coinsurance amounts, deductible amounts, copayment amounts, and amounts for non-covered services **— KRS 304.17A-527(1)(a).**

2. "**Any Willing Provider**" clause, health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan **— KRS 304.17A-270.**

3. "**Soliciting Applications for Provider Participation**" clause, health care benefit plans shall allow all providers who desire to apply for participation in the plan an opportunity to apply at any time during the year or annually for those insurers that do not conduct a continuous provider enrollment period — **KRS 304.17A-525(2).**

4. "**Most Favored Nation**" clause, no insurance contract with a provider shall contain provisions that allow the provider to have a better rate than other providers except where the Commissioner has determined that the market share of the insurer is nominal — **KRS 304.17A-560.**

5. "**GAG Rule**" omission of a clause. A managed care plan may not contract with a health care provider to limit the provider's disclosure to an enrollee, or to medical condition or treatment options. A health care provider shall not be penalized or a health care provider's contract with a managed care plan terminated, because the provider discusses medically necessary or appropriate care with an enrollee or another person on behalf of an enrollee.

    a. The health care provider may not be prohibited by the plan from discussing all treatment options with the enrollee; and

    b. Other information determined by the health care provider to be in the best interest of the enrollee may be disclosed by the provider to the enrollee, or to another person on behalf of an enrollee.

    c. A health care provider shall not be penalized for discussing financial incentives and financial arrangements between the provider and the insurer with the enrollee — **KRS 304.17A-530.**

6. "**A continuity of care**" clause that states that if an agreement between the provider and the managed care plan is terminated for any reason, other than for a quality of care issue or fraud, the provider shall continue to provide services and reimburse the provider in accordance with the agreement until the covered person is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy — **KRS 304.17A-527(1)(b.)**

7. "**A survivorship**" clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the managed care plan **— KRS 304.17A-527(1)(c).**

8. "**An all products**" clause. An insurer may not require a health care provider, as condition of participation in a health benefit plan; to participate in any of the insurer's other health benefit plans **— KRS 304.17A-150(4).**

9. A provider contract executed after January 1, 2001 between a managed care plan and a physician shall not require the mandatory use of a hospitalist — **KRS 304.17A-532.**

10. A provision identifying the products and markets applicable to any discount as provided in the contract — **KRS 304.17A-728(1.)**

11. An insurer or entity shall not reimburse on a discounted fee basis unless the disclosure is provided in the contract — **KRS 304.17A-728(2).**

12. An insurer shall process and pay claims in accordance with **KRS 304.17A-726**.

13. A clause requiring that, if a provider enters into any subcontract agreement with another provider to provide their licensed health care services to an enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, then the subcontract agreement must meet all the above requirements and all such subcontract agreements shall be filed with the commissioner — **KRS 304.17A-527(1)(e).**

14. A clause, stating that, upon request, the insurer will provide or make available to a participating provider, when contracting or renewing an existing contract with such provider, the payment or fee schedule or other information sufficient to enable the provider to determine the manner and amount of payments under the contract for the provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety days prior to the effective date of amendment **— KRS 304.17A-527(1)(d).**

15. An insurer may not reserve the right to terminate a provider contract without cause — **KRS 304.17A-525(4), KRS 304.17A-270** and **KRS 304.17A-171(2).**

16. Any change to payment or fee schedules applicable to providers under contract with an insurer issuing a managed care plan, shall be made available to such providers at least ninety days prior to the effective date of the amendment — **KRS 304.17A-577(2).**

17. If an insurer issuing a managed care plan makes a material change to an agreement it has entered into with a participating provider for the provision of health care services, then the insurer shall provide at least ninety (90) days written notice of the material change — **KRS 304.17A-578(2.)**

18. A participating provider who opts to withdraw following notice of a material change to the agreement, shall send written notice of withdrawal to the insurer no later than forty-five (45) days prior to the effective date of the material change — **KRS 304.17A-578(3).**

19. If an insurer makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change — **KRS 304.17A-578(4).**

20. Any contract between an insurer and its pharmacy benefits administrator that requires claims to be submitted electronically shall require that payment is to be made electronically to the participating provider or its designee for clean claims submitted electronically or if electronic payment is requested by the provider — **KRS 304.17A-705(2).**

21. Any contract between an insurer and a participating pharmacy or its contracting agency that requires claims to be submitted electronically shall require that payment is to be made electronically to the participating provider or its designee for clean claims submitted electronically or if electronic payment is requested by the provider — **KRS 304.17A-705(3).**